STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2010-41996 QHP
Case No. 1248480

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.,* following the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant, [redacted], appeared on his own behalf. The Medicaid Health Plan (MHP), [redacted], was represented by [redacted]. [redacted], and [redacted], appeared as witnesses for the MHP.

ISSUE

Did the MHP properly determine that the Appellant does not meet the eligibility criteria for a power scooter?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material, and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary, who has been enrolled in the MHP since [redacted]. (Exhibit 1, page 3)

2. The Appellant is [redacted], who underwent a lumbar fusion in [redacted] and has been diagnosed with spinal stenosis. (Exhibit 1, pages 7-8).

3. On [redacted], a request for a power scooter for the Appellant was received by the MHP. The request was not accompanied by supporting medical documentation as to why he could not propel a manual wheelchair. (Exhibit 1, pages 6-10).

4. On [redacted], the MHP contacted the medical supplier to request additional information. Specifically, the MHP requested a reason why a standard manual wheelchair could not be used. (Testimony of Almassy)

5. On [redacted], the MHP denied the request for a power scooter for the Appellant. The reason for denial was that there was no documentation to support why the Appellant cannot propel a manual wheelchair. (Exhibit 1, page 11).

6. On [redacted], the MHP received a second request for the power scooter. This second request included an addendum to the letter of medical necessity, stating that the Appellant is unable to use a manual wheelchair because of poor upper body strength. However, there was no medical documentation to support that assertion. (Exhibit 1, pages 15-19; Testimony of [redacted])

7. On [redacted], the MHP advised the Appellant's primary care physician (PCP) that it was denying the second request because the information provided in the addendum to the letter of medical necessity did not qualify the Appellant for a power scooter. (Exhibit 1, page 21)

8. On [redacted], the State Office of Administrative Hearings and Rules for the Department of Community Health received the Appellant's signed Request for an Administrative Hearing.

9. On [redacted], the MHP contacted the Appellant's orthopedic surgeon's office to request documentation evidencing medical necessity for a power scooter. The office advised the MHP that the Appellant had not been treated for upper body issues. (Exhibit 1, page 3; Testimony of [redacted])

10. On [redacted], the MHP once again contacted the Appellant's PCP and the officer manager stated that she could not find any documentation to support the Appellant's poor upper body strength. (Exhibit 1, page 3; Testimony of [redacted])

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified MHPs.

The Respondent is one of those MHPs.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. The Contractor must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the provisions of Contract Section 2.024.
>
> *Section 1.022(E)(1), Covered Services.*
> *MDCH contract (Contract) with the Medicaid Health Plans,*
> *October 1, 2009.*
>
> (1) The major components of the Contractor's utilization management (UM) program must encompass, at a minimum, the following:
>
> (a) Written policies with review decision criteria and procedures that conform to managed health care industry standards and processes.
>
> (b) A formal utilization review committee directed by the Contractor's medical director to oversee the utilization review process.

(c) Sufficient resources to regularly review the effectiveness of the utilization review process and to make changes to the process as needed.

(d) An annual review and reporting of utilization review activities and outcomes/interventions from the review.

(e) The UM activities of the Contractor must be integrated with the Contractor's QAPI program.

(2) Prior Approval Policy and Procedure
The Contractor must establish and use a written prior approval policy and procedure for UM purposes. The Contractor may not use such policies and procedures to avoid providing medically necessary services within the coverages established under the Contract. The policy must ensure that the review criteria for authorization decisions are applied consistently and require that the reviewer consult with the requesting provider when appropriate. The policy must also require that UM decisions be made by a health care professional who has appropriate clinical expertise regarding the service under review.

Section 1.022(AA), Utilization Management, Contract, October 1, 2009.

As stated in the Department-MHP contract language above, a MHP "must operate consistent with all applicable Medicaid Provider Manuals and publications for coverages and limitations." The pertinent section of the Michigan Medicaid Provider Manual states:

Power wheelchairs or Power Operated Vehicles (POV) may be covered if the beneficiary demonstrates all of the following:

- Lacks ability to propel a manual wheelchair or has a medical condition that would be compromised by propelling a manual one for at least 60 feet over hard, smooth, or carpeted surfaces.

- Requires the use of a wheelchair for at least four hours throughout the day.

- Able to safely control a wheelchair through doorways and over thresholds put to one-and one-half inches (e.g., the beneficiary's cognitive and physical abilities to safely operate the wheelchair).

MDCH may consider coverage of a POV, including custom or modified seating, rather than a more expensive power wheelchair if the beneficiary has sufficient trunk control and balance necessary to safely operate the device. Has a diagnosis/condition that indicates a lack of functional ambulatory status.

* * *

Noncovered Items

- Secondary wheelchairs for beneficiary preference or convenience.
- Standing wheelchairs for beneficiaries over 21 years old.
- Coverage of power tilt-in-space or recline for a long-term care resident because there is limited staffing.
- Non-medical wheelchair accessories such as horns, lights, bags, etc.
- New equipment when current equipment can be modified to accommodate growth.

Documentation The documentation must be within 180 days, and include the following:

- Diagnosis appropriate for the equipment requested.
- Occupational therapy or physical therapy evaluation and recommendation.
- Brand and model of requested wheelchair.
- If a replacement wheelchair is requested, list brand, model, serial number and age of current chair.
- Medical reason for add-on components or modifications, if applicable.
- Specific medical condition (e.g., contractures, muscle strength) if seating system requested.

- Current ambulatory status of beneficiary (e.g., distance the individual can walk, the level of assistance required).

- Any adaptive or assistive devices currently used (if replacement chair is requested, list brand, model, serial number and age of current chair).

- Other cost-effective alternatives that have been ruled out.

- A pediatric subspecialist is **required under the CSHCS Program**.

Department of Community Health,
Medicaid Provider Manual, Medical Supplier
Version Date: April 1, 2010, Pages 80-83

The MHP witnesses explained that the power scooter was denied in this case because there was no medical documentation to support that the Appellant is unable to propel a manual wheelchair. The MHP acknowledged that the addendum to the letter of medical necessity provided by the Appellant's physician did indicate that the Appellant is unable to propel a manual wheelchair due to lack of upper body strength. However, the MHP stated that it needs some medical documentation to support that assertion. The MHP witnesses further testified that the Appellant's PCP and orthopedic surgeon were contacted and asked to provide supporting medical documentation, but no additional documentation was provided to the MHP.

The Appellant testified that he had back surgery in [redacted], and since that time, has had issues with walking. He stated that he can walk 30 to 40 feet with his walker, but his legs keep giving out on him. He further testified that he is able to propel a manual wheelchair for short distances, approximately 20 feet or so, in the house. He stated that he does not have the upper body strength to propel it for long distance or outside of the house. However, he failed to provide any medical documentation to support this assertion.

This Administrative Law Judge has reviewed the record evidence in this case and concludes that the MHP's denial of the Appellant's request for a power scooter was. proper. There is no medical documentation to support the assertion that the Appellant is unable to propel a manual wheelchair. The Appellant was provided an opportunity to submit the documentation to this Administrative Law Judge. He did not do so.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the MHP properly denied Appellant's request for a power scooter. However, should the Appellant obtain the required medical documentation, he may resubmit his request.

IT IS THEREFORE ORDERED that:

The MHP's decision is AFFIRMED.

Kristin M. Heyse
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/8/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.